Experience More to Life Adult Day Health Center, LLC

CLIENT MEDICAL REPORT

Please have this form completed by the client's physician office (M.D., P.A., or Nurse Practitioner) and returned to *More to Life* upon to enrollment and yearly thereafter. Please fax to: **(775) 358-1588**.

Client Name: _____ Birth Date: _____ Today's Date:_____

Date of last Dr. visit:_____ Caregiver Phone Number: _____

Primary **Diagnosis**: _____

Temperature: _____ Pulse: _____ Resp: _____ Blood Pressure: _____ SpO2: _____ Weight: _____

Please list all **client conditions** that might restrict activities or require special attention at an adult day center (physical, mental, emotional, immune system, contagious illness, allergies, special equipment, diet, etc.):

_____

_____

As the Primary Care Physician, **I recommend** that this patient attend Adult Day Care for socialization, exercise, mental stimulation, and other health benefits at least _____ (please write a number 0 to 6) times per week.

Please attach a **list of all medications** that the client is taking and **diet restrictions**.

More to Life keeps the following **Over-the-counter medicines** on hand in the facility.
Please indicate which, if any, of these medications may be given to the client as needed.

OTC / PRN Medication	Strength	Dose and Instructions	To be given for:	Dr. initials if OK
Advil (Ibuprofen tablets)	200 mg	1 tablet PO every 6 hours	Pain / Fever	
Aleve (Naproxen sodium tablets)	220 mg	1 tablet PO every 12 hours	Pain / Fever	
Loperamide HCl (Imodium)	2 mg	2 tablets PO (up to 4 tablets/24 hours)	Anti-diarrheal	
Milk of Magnesia (Magnesium Hydroxide)	Liquid	30 ml PO once daily	Constipation/ Irregularity / Heartburn / Indigestion	
Tylenol (Acetaminophen tablets)	325 mg	2 tablets PO every 6 hours	Pain / Fever	
TUMS E X (calcium carbonate chewables)	750 mg	2 tablets PO every 6 hours	Heartburn / Indigestion	
DESITIN (Zinc Oxide)	Topical	Apply liberally as often as needed	Diaper Rash / Minor Burns Severely Chapped Skin	

I certify that I have reviewed the health history and examined this person and find him/her acceptable to participate in an adult day health care program.

Signed: _____ **Date: _____**
M.D., P.A., or Nurse Practitioner

Print: _____ **Phone:_____**

Address:_____